OrthoArizona
Arizona Orthopaedic Associates

WELCOME TO OUR OFFICE

PID#

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

(Please check preferred contact number)

Date: _____

1 (_____) _____
☐ Home ☐ Work ☐ Cell

_____ _____ _____
PATIENT LAST NAME FIRST NAME MIDDLE

2 (_____) _____
☐ Home ☐ Work ☐ Cell

_____ _____ _____ _____ _____ _____
APT/LOT # CITY STATE ZIP ADDRESS

_____ _____ _____ **SEX:** ☐ Male _____
SOCIAL SECURITY NUMBER DATE OF BIRTH AGE ☐ Female PRIMARY CARE PHYSICIAN

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ REFERRED BY

Race: ☐ White/Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American

_____ (_____) _____
EMPLOYED BY WORK PHONE

_____ _____
OCCUPATION E-MAIL

SPOUSE OR SIGNIFICANT OTHER INFORMATION

_____ _____ (_____) _____
NAME DATE OF BIRTH PHONE #

IN CASE OF EMERGENCY

_____ _____ (_____) _____
NAME OF PERSON IN CASE OF EMERGENCY OTHER THAN SPOUSE RELATIONSHIP EMERGENCY PHONE

IF THE PATIENT IS A MINOR OR STUDENT

_____ _____ _____ (_____) _____
RESPONSIBLE PARTY RELATIONSHIP D.O.B. HOME PHONE

_____ _____ _____ _____ _____
ADDRESS CITY STATE ZIP SOCIAL SECURITY NUMBER

PRIMARY INSURANCE INFORMATION

_____ _____ _____ (_____) _____
INSURANCE COMPANY NAME POLICY HOLDER'S NAME POLICY HOLDER'S DOB PHONE

POLICY# _____ GROUP# _____ SOCIAL SECURITY NUMBER: _____

PATIENT RELATION TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

SECONDARY INSURANCE INFORMATION

_____ _____ _____ (_____) _____
INSURANCE COMPANY NAME POLICY HOLDER'S NAME POLICY HOLDER'S DOB PHONE

POLICY# _____ GROUP# _____ SOCIAL SECURITY NUMBER: _____

PATIENT RELATION TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

IS YOUR CONDITION RELATED TO AN ACCIDENT OF ANY KIND? ☐ NO ☐ YES ☐ WORK RELATED ☐ AUTO ACCIDENT

☐ OTHER (EXPLAIN) _____ DATE OF INJURY: _____

DO YOU HAVE LEGAL ACTION PENDING REGARDING THIS INJURY? ☐ NO ☐ YES ATTORNEY NAME & PHONE: _____

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS **YOUR RESPONSIBILITY** TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST ARIZONA ORTHOPAEDIC ASSOCIATES AT GATEWAY, A DIVISION OF OSNA PLLC, TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE, AND FOR THE PURPOSE OF ADMINSTERING CLAIMS. I HAVE BEEN MADE AWARE OF AOA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGMENT OF PAYMENT OF MY MEDICAL BENEFITS TO AOA AT GATEWAY, A DIVISION OF OSNA PLLC. I UNDERSTAND I MAY RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS WILL BE YOUR RESPONSIBILITY.

PATIENT/ PARENT/ GUARDIAN SIGNATURE: _____ **DATE:** _____ Updated on 2-11-13